Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 6, 2016	2016_334565_0002	004085-14, 000069-15, 004795-15, 007036-15, 008992-15, 010696-15, 030363-15	Critical Incident System

Licensee/Titulaire de permis

VILLA COLOMBO HOMES FOR THE AGED, INC.
40 PLAYFAIR AVENUE TORONTO ON M6B 2P9

Long-Term Care Home/Foyer de soins de longue durée

VILLA COLOMBO HOMES FOR THE AGED INC.
40 PLAYFAIR AVENUE TORONTO ON M6B 2P9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 17, 18, 22, 23, 24, 25, and 26, 2016.

During the course of the inspection, the following Critical Incident Intakes were inspected by inspector #566 during inspection #2016_340566_0005: 004253-15, 011563-15, 011943-15, 015685-15, 017105-15, and 017510-15. Finding of non-compliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 19. related to residents #012, #013 and #016 is issued together with the non-compliances of this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Resident Services (DORS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staff training records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

As per the Long-Term Care Homes Act, 2007:
- Physical abuse means the use of physical force by a resident that causes physical injury to another resident.

A review of critical incident system (CIS) report and the incident notes revealed on an identified date, resident #005 was noted wheeling himself/herself on the unit and exhibiting responsive behaviours. PSW intervened and attempted to wheel resident #005 to his/her room. While wheeling the resident, he/she demonstrated responsive behaviours towards resident #006. Resident #006 lost balance and fell, and sustained an identified injury.

A review of resident #005 and #006's plans of care, Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments and progressive notes indicated both residents were cognitively impaired, and resident #005 had a history of exhibiting responsive behaviours toward others.

An interview with RPN #102 indicated he/she witnessed the incident. The staff member confirmed on that day, resident #005 exhibited responsive behaviours. He/she heard resident #006 scream and saw resident #005 exhibit the identified responsive behaviours towards resident #006. As a result, resident #006 fell and sustained the injury.

The home has failed to protect resident #006 from physical abuse by another resident. [s. 19. (1)]

2. a. A review of CIS report revealed that on an identified date in March 2015, residents #011 and #012 had an incident resulting in injuries to both residents. A review of resident #011 and #012's plans of care, RAI-MDS assessments and progress notes indicated both residents were cognitively impaired and had a history of exhibiting responsive behaviours toward staff and other residents.

A review of CIS report and progress notes for resident #011 revealed that on a second identified date in March 2015, an incident occurred between residents #011 and #012 in an identified common area. An identified staff member responded and separated the residents. When the residents were assessed post-incident, resident #012 was noted to have sustained an identified injury.

Staff interviews revealed that resident #011 is cognitively impaired, and had responsive behaviours towards both staff and co-residents. Interviews with PSW #114, #112, and RPN #111 confirmed that on the second identified date, an incident ensued between residents #011 and #012. PSW #112 overheard this incident and responded and intervened, sustaining an injury to himself/herself in the process of trying to separate the residents. Both PSWs #112 and #114 confirmed that resident #012 had an identified injury caused by resident #011 following the incident.

An interview with PSW #114 revealed that resident #011 remained agitated following the incident with resident #012. RPN #111 confirmed that the resident was being closely monitored following the incident until he/she settled, and was then monitored as per his/her plan of care.

Further record review of resident #011's incident notes and CIS report revealed, and staff interviews confirmed that later on the same identified date, a second, unwitnessed incident involving resident #011 occurred. According to the CIS report, a staff member overheard an incident and attended to resident #013, where resident #011 was observed to be nearby in a threatening stance. The identified staff member immediately intervened and separated residents #011 and #013. When the residents were assessed post-incident, resident #013 was noted to have sustained an identified injury.

An interview with RPN #111 confirmed that the police were notified regarding both incidents and no charges were laid.

b. A review of CIS report and progress notes for resident #011 revealed that on an identified date in June 2015, an incident occurred between resident #011 and resident #016. An identified PSW reported that resident #011 entered resident #016's room while resident #016 was sleeping, and injured resident #016.

When the residents were assessed post-incident, resident #016 was noted to have sustained multiple identified injuries.

A review of resident #016's written care plan revealed that resident #016 is cognitively impaired and has a history of exhibiting responsive behaviours.

Staff interviews with PSW #110 and RPN #113 confirmed that an incident occurred between residents #011 and #016 on the identified date in June 2015. PSW #110 overheard resident #016's calls for help coming from his/her bedroom. By the time PSW

#110 was able to respond, resident #011 was observed to be in a common area in the vicinity of resident #016's room. Resident #016 reportedly appeared very agitated and upset. PSW #110 confirmed that resident #016 had sustained an identified injury following the incident, and that the only cause of the injury could have been resident #011 as no one else was in the area at the time.

An interview with the DORS confirmed that by the nature of the incidents and the injuries sustained by residents #012, #013 and #016, the identified residents were not protected from abuse by resident #011. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of resident #005's plan of care and RAI-MDS assessment revealed the resident was required to wear eyeglasses for reading and for distance at all times.

On two identified dates, the inspector observed the resident was sitting on a wheelchair outside the nursing station facing the television and in his/her room respectively, and the resident was alert and not wearing eyeglasses.

An interview with PSW #106 indicated he/she usually puts on the eyeglasses for the resident. On that date, when he/she started the shift in the morning, he/she was unable to find the eyeglasses for the resident. Therefore the resident was not wearing the eyeglasses.

An interview with RPN #107 confirmed that the resident should wear the eyeglasses and he/she did not know when the eyeglasses went missing. The staff member confirmed the care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at any other time when the resident's care needs changed.

A review of resident #005's RAI-MDS assessment revealed the resident had physical impairment and required a mechanical lift and staff assistance. A review of the care plan did not include use of the mechanical lift.

An interview with PSW #106 indicated staff had been transferring the resident with the specified mechanical lift and staff assistance. An interview with RPN #107 confirmed that the resident's transfer required the specified mechanical lift and staff assistance, and the plan of care was not revised as required. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed, of an incident that caused an injury to a resident for which the resident was taken to hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A review of the CIS report revealed resident #004 fell on an identified date in an identified home area. The resident was sent to the hospital on the same day and he/she sustained a fracture. The incident was reported to the CIS four days later.

A review of the progress notes and interview with the DORS indicated the home was notified about the resident's fracture on the same day when the resident was sent to the hospital. The DORS confirmed the incident was not reported to the Director until four business days after the occurrence of the incident. [s. 107. (3) 4.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, falls prevention and management training was provided to all staff who provided direct care to residents.

A review of the staff training attendance record for falls prevention and management revealed and an interview with the DORS confirmed that four per cent of the direct care staff did not receive the training in 2015 as required. [s. 221. (1) 1.]

Issued on this 8th day of April, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.